FIRST THINGS FIRST

1921 S. Alma School Rd. Suite #111
Mesa AZ 85210
Phone: 602 771 4988
Fax: 480 755.3263
www.azftf.gov



December 29, 2009

Dear Arizona Early Childhood Development and Health Board Members,

During the initial development of the FY 2010 funding plan by the Southeast Maricopa Regional Partnership Council, funds were set aside for regional developmental screening activities. The Screening RFGA was cancelled due to an inadequately written RFGA. For this reason, the Southeast Maricopa Regional Partnership Council has been working diligently to re-establish the region's priorities relating to developmental screening. On December 15, 2009, the Southeast Maricopa Regional Partnership Council determined that it would be in the best interest of the communities in which the Regional Partnership Council serves, to reallocate the $657,000 from the cancelled Screening RFGA and shift the funding in order to support, enhance, and implement comprehensive programs that provide health education and screening activities for children ages 0-5, therefore increasing children's access to preventive health care through a medical home model.

According to the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, & American Osteopathic Association (2007), the key elements of the medical home are: a physician who has an ongoing relationship with patients and arranges care with other qualified professionals; the implementation of evidence-based medicine, quality improvement measures, information technology, and patient participation in care decisions; improved access to care that includes open scheduling, expanded hours, and new options for communication with patients; and a payment system that recognizes the medical expertise, administrative requirements, and time demands of providing a personal medical home.

A medical home is not a place. It is an approach and process to healthcare in the primary care setting. It emphasizes a partnership among the patient, physician, practice staff, and, if present, the primary caregiver. The practice becomes the place (or home) where patients are known, recognized and supported; where they find a centralized base for medical care and connection to other medical and supportive community services.

First Things First, at the state level, will seek proposals through the RFGA process for a three year, statewide Physician Outreach and Education Initiative to include:

- Practice assessments and implementation plans to improve the delivery of preventive service such as immunizations, lead screening, anemia risk screening, tobacco risk exposure, sleep position risk identification, dental screening, and vision screening in accordance with standards of preventive care
- On site education and coaching on enhanced use of parent assessments, parent education and establishment of medical homes
- Onsite technical assistance and coaching on establishing systems to track referrals to early intervention services based on level of delay
- Information about referral pathways and intervention services when delays are identified
- Development of collaborative learning groups to identify barriers to quality practice and develop plans and strategies to achieve practice-based quality improvement activities
- Integrate lessons learned and best practices in physician continuing education programs

Year One includes outreach to build physician practice involvement and will be managed by a Practice Management Advisor. The Statewide strategy targets 50 practices in year one throughout the state, 100 practices in year two and 100 practices in year three.

The Southeast Maricopa Regional Partnership will fund the participation of an *additional seven* practices within the Southeast Maricopa Region. Attempts will be made to include a minimum of two practices for each of the communities in the region (Mesa, Gilbert and Queen Creek).

At this time, the Southeast Maricopa Regional Partnership Council would like to request that the Arizona Early Childhood Development and Health Board approve the Regional Partnership Council's petition to reallocate $657,000 for regional participation in the Medical Home Model.

Sincerely,

Denise D. Tamminen

Denise Tamminen, Council Chair
Southeast Maricopa Regional Partnership Council

**Strategy 11**

**Support, enhance, and implement comprehensive programs that provide health education and screening activities for children ages 0-5. Increase children's access to preventive health care through a medical home model.**

According to the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, & American Osteopathic Association (2007), the key elements of the medical home are: a physician who has an ongoing relationship with patients and arranges care with other qualified professionals; the implementation of evidence-based medicine, quality improvement measures, information technology, and patient participation in care decisions; improved access to care that includes open scheduling, expanded hours, and new options for communication with patients; and a payment system that recognizes the medical expertise, administrative requirements, and time demands of providing a personal medical home.

A medical home is not a place. It is an approach and process to healthcare in the primary care setting. It emphasizes a partnership among the patient, physician, practice staff, and, if present, the primary care giver. The practice becomes the place (or home) where patients are known, recognized and supported; where they find a centralized base for medical care and connection to other medical and supportive community services.

Piecing together health services and supports for any family is daunting, it is especially challenging for the families and service providers that serve children who are facing complex or crisis situations, including children with special health needs, children in families experiencing domestic violence, and families who are homeless.

The Needs and Assets report for the region shows there is a real need for the use of a medical/dental home model in the region. The research from both the medical/dental home model is promising. It is the Southeast Maricopa Regional Partnership Council's desire to dedicate a significant proportion of its funding toward this strategy.

**Strategy Components**

**A:** ***The Southeast Maricopa Regional Partnership Council will collaborate with the State Board Health Strategy to conduct Physician Outreach and Education. Funding will be provided to conduct physician outreach, technical assistance and coaching to ten medical practices throughout the Southeast Maricopa region, including pediatric practices, family medicine, Federally Qualified Health Centers (FQHC), Community Health Centers, Indian Health Services and Tribal Health facilities.***

Physician outreach and education is a quality improvement strategy with the goal of assisting physicians in identifying the health system and practice procedures that need to change or be implemented that would result in consistent quality care for children. Physicians involved in a quality improvement strategy engage in activities that includes assessment of their delivery systems and development of a plan for improvement. They will receive technical assistance and coaching as well as materials to support clinical practice improvement. Additional support may also be provided through the formation of collaborative learning groups that commit to the quality improvement process.

First Things First, at the state level, will seek proposals through the RFGA process for a three year, statewide Physician Outreach and Education Initiative to include:

- Practice assessments and implementation plans to improve the delivery of preventive service such as

immunizations, lead screening, anemia risk screening, tobacco risk exposure, sleep position risk identification, dental screening, and vision screening in accordance with standards of preventive care.

- On site education and coaching on enhanced use of parent assessments, parent education and establishment of medical homes.
- Onsite technical assistance and coaching on establishing systems to track referrals to early intervention services based on level of delay.
- Information about referral pathways and intervention services when delays are identified.
- Development of collaborative learning groups to identify barriers to quality practice and develop plans and strategies to achieve practice-based quality improvement activities.
- Integrate lessons learned and best practices in physician continuing education programs.

Year One includes outreach to build physician practice involvement and will be managed by a Practice Management Advisor. The Statewide strategy targets 50 practices in year one throughout the state, 100 practices in year two and 100 practices in year three.

The Southeast Maricopa Regional Partnership will fund the participation of an *additional seven* practices within the Southeast Maricopa Region. Attempts will be made to include a minimum of two practices for each of the communities in the region (Mesa, Gilbert and Queen Creek).

**B. *The Southeast Maricopa Regional Partnership Council will establish Medical Home Care Coordinators for the practices chosen to participate in the Physician Outreach and Education project mentioned in part A of this strategy.***

The medical home represents a standard of primary care where children and their families receive the care they need from a family physician, pediatrician or healthcare professional that they trust. Healthcare professionals in partnership with the family work with appropriate community resources and systems to achieve the child's maximum potential and optimal health. A medical home addresses well-child care, acute care, and chronic care for all children from birth through their transition to adulthood

An important component of a medical home is service coordination and case management to provide linkages for children and their families with appropriate services and resources in a coordinated effort to achieve good health. According to the Medical Home Practice-Based Care Coordination workbook (McAllistar, Presler, Cooley); "It has been suggested that you cannot be a strong medical home without the capacity to link families with a designated care coordinator.

In order to weave a sometimes patchwork of health and social services into a coherent and comprehensive system of services, the Southeast Maricopa Regional Partnership Council will provide care coordination through the use of Medical Home Care Coordinators. Effective care coordination enhances access to needed services and resources, promotes optimal health and functioning of children, and supports improved quality of life. Data shows that primary care physicians struggle to fulfill the care-coordination needs of children, youth, and families. Care is coordinated and/or integrated across all elements of the complex health care and social services systems (e.g., subspecialty care, hospitals, home health agencies) and the patient's community (e.g., family, schools, childcare, public and private community-based services,). Care coordinators will enhance the abilities of the physician and practice to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Responsibilities of the care coordinators working with the identified practices may include, but are not limited to

assisting in:

1. scheduling
2. assessing patient (and families') needs
3. planning and implementation of care
4. assurance of access to care (insurance or social services)
5. authorization of services
6. service monitoring
7. reporting to the physician regarding the coordination of care.
8. tracking referrals
9. brokering or obtaining resources
10. family support and education.
11. provide service coordination with other community resources, to make an effort to minimizing duplication and to ensuring that families receive comprehensive services as needed

Medical Home Care Coordinators will NOT be responsible for performing medical procedures or treatments, giving medical advice, writing reports generally prepared by physicians or nurses and performing routine bookkeeping, clerical or billing functions.

It is also the desire of the Southeast Maricopa Regional Partnership that there will be collaborative working relationships between the practices identified above, the Medical Home Care Coordinators, Quality First Child Care centers and the Child Care Health Consultants located in the region. In addition, the practices involved in the Physician Outreach and Education and Medical Home Care Coordinators will be required to actively participate in the cross regional coordination strategy of both the Southeast and Central Maricopa Regional Partnership Councils. It is through this strategy that a Family Support Network will be established to provide mechanisms to coordinate a cross-system of family support, early childhood development, early care and education, health care and parenting education programs. The Family Support Network will provide Resource Management, Network Coordination for both regions. The Medical Home Care Coordinators will work closely with the Family support Network staff to ensure the coordination of service providers.

C. ***Support physicians, practices and clinics involved in the learning collaborative identified in part A to fund specific activities that will increase children's access to medical homes by making necessary changes within a practice or clinic that will enhance their ability to achieve certification from the National Center for Quality Assurance in being a Medical Home.***

Patient Centered Medical Homes are health care settings that facilitate partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by networks, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

The National Center for Quality Assurance offers certification in being a Medical Home. The Physician Practice Connections – Patient-Centered Medical Home (PPC®-PCMH™) program reflects the input of the American College of Physicians (ACP), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP) and American Osteopathic Association (AOA) and others in a revision of Physician Practice Connections® to assess whether physician practices are functioning as medical homes. Building on the joint principles developed by the primary care specialty societies, the PPC®-PCMH™ standards emphasize the use of systematic, patient-

centered, coordinated care management processes.

Many private and public health plans and employers are considering projects to recognize and compensate practices as patient-centered medical homes. Many large health plans, as well as Medicare and Medicaid, are planning demonstration projects to learn more about how practices can become medical homes. The quality and cost advantages of doing so will allow physicians to help families with young children address health issues in preventive care such as screening measures in vision, hearing , physical and developmental growth as well as acute care. Children with special health care needs will also benefit.

The council recognizes that many practices and clinics may not have the resources necessary to achieve certification or to implement necessary changes in order to function as a medical home. Participating practices and clinics will have support in making necessary improvements and achieving the three different levels of certification from The Physician Practice Connections – Patient-Centered Medical Home (PPC®-PCMH™).

Grants of up to $4,000 - $10,000. will be awarded each year to practices and clinics involved in the learning collaborative in part A of this strategy to make the necessary changes within the practice or clinic in order to achieve the nine PPC®-PCMH™ standards for medical practices to meet, including use of patient self-management support, care coordination, evidence-based guidelines for chronic conditions and performance reporting and improvement. These changes should lead to activities that must be sustained after grant implementation.

Patient care associated with the Medical Home improves outcomes, such as health status, timeliness of care, family centeredness and family functioning. The NCQA PPC-PCMH standards provide a way to qualify and quantify care in the Medical Home.

The Southeast Maricopa Region will join the state board strategy in seeking proposals through the RFGA process for a three year, statewide Physician Outreach and Education Initiative for Part A of the strategy. Parts B and C will be implemented through a Regional RFGA process. Grantees must provide a clear and realistic sustainability plan following this three year funding opportunity. Proposals must also clearly demonstrate coordination with community resources to ensure that existing efforts are not duplicated.

**Lead Goal: FTF will build on current efforts to increase the number of health care providers utilizing a medical and dental home model.**

**Goal:** FTF will lead cross-system coordination efforts among state, federal and tribal organizations to improve the coordination and integration of Arizona programs, services, and resources for young children and their families.

**Key Measures:**

1. Total number and percentage of children with health insurance
2. Total number and percentage of children receiving appropriate and timely well-child visits
3. Total number and percentage of health care providers utilizing a medical home model
4. Ratio of children referred and found eligible for early intervention

**Target Population:**

Target population will include physicians, practices and clinics who currently do not use a medical home model c

do not have the resources to implement a medical home model.

| Proposed Service Numbers | SFY2010 July 1, 2009 – June 30, 2010 | SFY2011 July 1, 2010 – June 30, 2011 | SFY2012 July 1, 2011 - June 30, 2012 |
|---|---|---|---|
| | **A:** 7 Practices (average 4 physicians/practice)<br><br>**B: 7** Care Coordinators | **A:** 7 Practices (average 4 physicians/practice)<br><br>**B: 7** Care Coordinators | **A:** 7 Practices (average 4 physicians/practice)<br><br>**B:** 7 Care Coordinators |

**Performance Measures SFY 2010-2012**

1. **% of medical health care professionals that use a medical home model/Strategic target.**
2. **# of children with health insurance/proposed service #.**
3. **# of children with health insurance under 150% - 200% poverty level/proposed service #.**

- How is this strategy building on the service network that currently exists:
  The Regional Partnership Council intends to increase the number of families and physicians using a medical/dental home model. There are many opportunities to work with existing family resource agencies in community-based settings.

- What are the opportunities for collaboration and alignment:
  There are opportunities to coordinate with resources already in place and build partnerships with clinics, community resources and programs to guide families and physicians to use a medical home model. Networking and collaboration of grantees and existing resources is essential. To maximize effectiveness and efficiency of training efforts, the Regional Council believes such efforts should be coordinated with professional associations such as the Academy of Pediatrics, as well as area hospitals and clinics.

  The Southeast Maricopa Regional Partnership and the Central Maricopa Regional Partnership have a Coordination strategy in which the regions will develop a mechanism to provide all families with a comprehensive system of family support, early care and education, health care and parenting education programs that ensures all families have access to the information and support they need to be effective parents. Participants in this strategy will be required to participate in the network of resource providers. Having access to and the use of a Medical Home will ensure families have access to comprehensive medical care and the coordination of needed social services.

**SFY2010 Expenditure Plan for Proposed Strategy**

| | |
|---|---|
| Population-based Allocation for proposed strategy | **Total: $657,000** |

**Budget Justification:**
**A:** Physician Outreach and Education: 7 practices @ 6,500. /yr. = 45,000

**B:** Cost for seven full-time Medical Home Care Coordinators is estimated at $80,000 each (inclusive of salary, ERE, supplies and mileage reimbursement) for a total of $560,000. The administrative entity that will employ, possibly house and supervise the Medical Home Care Coordinators will be determined through a competitive

RFGA process. Medical Home Care Coordinators could be housed within the administrative agency or within specific clinics or practices depending on the determination of how best to deliver their services. A realistic sustainability plan must be submitted with the grant proposal for these services. Examples of this may include a cost share by the Physician/Practice for the funding of the Care Coordinator in years two and three. Example: Year One: Grantee funds 100% of the FTE Care Coordinator. Year Two: Grantee funds 80% and Physician/Practice funds 20%. Year Three: Grantee funds 60% and Physician/Practice funds 40%

C. 7 practices X up to 7,000. = $49,000. Grants from $4,000 to $7,000 for practices or clinics (depending on size of practice) involved in the Physician Outreach and Education Learning Collaborative to implement changes necessary to be a medical home model.